Office for Students with Disabilities
Request for Services & Academic Accommodations, Part I

Part I: Basic Information, for Student to Complete & Return to <OSWD@Gallaudet.edu>

Full Name		Gallaudet ID #	
Pronouns		Social Security #	
Email		Term/Year Admitted to GU	
Major Field of Study		Term/Year Expected Graduation	

Status	◯ Undergraduate	◯ Graduate	◯ ELI	◯ Prof. Studies	◯ Special

Gender Identity	◯ Female	◯ Trans Female	◯ Genderqueer	◯ Non-Binary	◯ Other
	◯ Male	◯ Trans Male	◯ Androgynous	◯ Intersex	◯ No Answer

Auditory Status	◯ Deaf	◯ Hard of Hearing	◯ Hearing	

Home Address	
Previous Colleges or Universities, years, and degrees or certificates, if any:	

Disabilities for which you are requesting services:	
Briefly describe how your disabilities affect your potential to succeed in course work and classes:	
I (*student name*):	
hereby authorize (*medical professional in Part III*):	
to discuss with Gallaudet University Office for Students with Disabilities (OSWD), my confidential medical information in Part III, for purposes of determining academic disability accommodations.	
Student Signature	Date

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Part II: Authorization to Share Information, for Student to Complete & Return to <OSWD@Gallaudet.edu>

I hereby authorize the Office for Students with Disabilities (OSWD) at Gallaudet University to obtain information from and/or release information to: *(Please check all that apply)*

☐	Student's Medical Personnel		☑	Gallaudet Faculty/Staff
☐	Counseling & Psychology Services (CAPS)		☐	Gallaudet Residence Life
☐	Vocational Rehabilitation Counselor		☐	Student Health Services
☐	Career Center			

	Other (specify →)	Name	
	(e.g., Parents)	Address	
		Phone/Fax	
		e-mail	

The purpose of this release is to help ensure I receive reasonable accommodations as listed in my medical and/or diagnostic records in compliance with the Americans with Disabilities Act of 1990 and subsequent amendments, and the Rehabilitation Act of 1973.

I understand that this Confidential Release of Information shall remain in force until such time as I withdraw it in writing, or I cease to be enrolled in the University.

Student Name		Student ID Number
Student Signature		Date

Office for Students with Disabilities
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Part III: Medical Information, for Licensed Medical Professional to Complete & Return to < OSWD@gallaudet.edu >.

Student's Name		Date of Last Contact	
Diagnosis		Date of Diagnosis	
Presenting symptoms & impacts of the disability?			
What instruments or procedures were used to diagnosis this disability?			
Does the student take medication for this disability? Side effects?			
How does the disability affect the student's academic performance?			
What accommodations would you suggest, and why?			

Signature		Date	
Name & Title		License #	
Office or Agency Name / Full Address & Phone			
Please attach any additional information that will help us understand the student's disability-related academic needs. Our office may contact you to confirm or clarify information provided.			